2011

Open Enrollment Booklet

The Year 2011 Open Enrollment Period Runs From
OCTOBER 11, 2010 through OCTOBER 29, 2010

City of Milwaukee

Department of Employee Relations
Employee Benefits Division
City Hall, Room 706
200 East Wells Street
Milwaukee, WI 53202
(414) 286-3184
www.Milwaukee.gov/der

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Other Benefit Information enclosed in this Open Enrollment packet:

- ***Benefit Information Statement***
- ***Group Life and Enhanced Group Life: (Fire & Police enrolled automatically)***
  - Supplemental Group Life Insurance Informational Brochure.
  - 1/3 page Supplemental Group Life Insurance card application (HACM & WCD employees only).
- ***Flexible Choices Program***
  - You must **enroll** or **re-enroll** during the Open Enrollment as described in the enclosed material. (Re-Enrollment is not automatic.)
- ***Long Term Disability Program: (excludes Fire and Police)***
  - See enclosed information booklet.
- ***Deferred Compensation***
  - See enclosed brochure.

HEALTH & DENTAL OPEN ENROLLMENT

Annual Open Enrollment - October 11, 2010 through October 29, 2010

The City's Annual Open Enrollment period is upon us once again. ***Active employees,*** please see the 2011 Employee Contributions on the first page of your Benefit Information Statement.

The rates may influence your health plan choice for the year 2011. When this booklet was printed, the City had not established Health/Dental terms for 2011 will all employee groups. As a result the rates may change during the calendar year.

The Basic Plan and United Healthcare Choice Plan (UHC) will be offered in 2011.

Those groups that settle their contracts late in 2010 or in 2011 can expect a premium and benefit change. The benefit structures can be subject to change during the calendar year based on a labor contracts.

This is your only opportunity during the year to make a change to your health or dental plan for plan year 2011**. If you are in the Basic Plan, UHC, WPS/Delta Dental, Dental Blue or Care-Plus Dental and do not want to change, you do not need to do anything.**

Review the information in this booklet, especially the plan comparison tables (beginning on page 8) and the enclosed Benefit Information Statement. If you want more information about a particular plan, call the health or dental plan directly and they will mail you their packet of information about provider hospitals. Their phone numbers and the websites are on page 30. You may also pick up plan information packets at the Open Enrollment Fairs as listed on page 3, or at the Employee Benefits office in City Hall Room 706.

All Active employees will use the online Employee Self Service Program for plan changes. The system is accessed with a web browser at work or home. Login on the Internet at https://cmil.mycmsc.com, and then click HRMS PRD 8.8 on the left side. All employees must have their Employee ID Number and a Password. To request or reset a password you can send an email to www.Milwaukee.gov/FMISpasswordhelp.

HEALTH PLANS - YEAR 2011

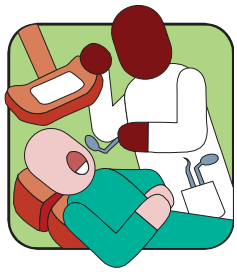
BASIC PLAN – The City's self-funded Indemnity Plan (administered by Anthem Blue Cross Blue Shield) 1-866-926-7789, www.Anthem.com.

UHC CHOICE PLAN - The City has contracted with the **United Healthcare (UHC) Choice Plan** to provide the following plan:

- **United Healthcare (UHC) Choice Plan – 1-866-873-3903, www.myuhc.com. UHC will offer two benefit structures based on labor contracts in 2011.**

The benefits structure can be subject to change based on a labor agreement and may change during the calendar year. You will note from the Comparison Chart (see pg. 8) that United Healthcare (UHC) Choice Plan uses the same "UNIFORM BENEFITS" that other HMO plans use. We refer to this benefit structure as "UNIFORM BENEFITS." See the paragraph at the bottom of pg. 12. UHC will offer two benefit structures based on current labor contracts. Both are summarized on page 8.

DENTAL PLANS - YEAR 2011



The City has contracted with three dental plans in 2011; they are listed below:

- **WPS/Delta Dental**
- **Dental Blue**
- **Care-Plus Benefit Plans, Inc.**

Open Enrollment Information Fairs

The City will hold Five (5) Open Enrollment Fairs that are open to all City employees and retirees. The schedule is listed below.

Thursday, October 7 - 1:00 p.m. to 6:00 p.m. ..... Wilson Park Senior Center
..... 2601 West Howard Avenue

Thursday, October 14 - 9:00 a.m. to 1:00 p.m. ..... City Hall Rotunda
..... 200 East Wells Street

Thursday, October 14 – 3:30 p.m. to 6:00 p.m. ..... Fire and Police Academy
..... 6680 North Teutonia Avenue

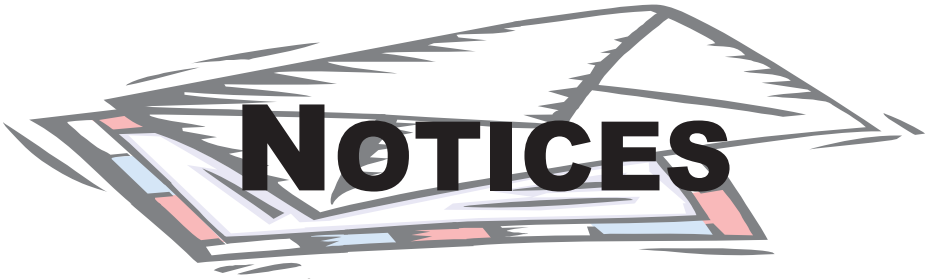
Thursday, October 21 – 12:00 p.m. to 4:00 p.m. ..... Bayview Public Library
..... 2566 South Kinnickinnic Avenue

Tuesday, October 26 – 11:00 a.m. to 4:00 p.m. ..... DPW Field Headquarters
..... 3850 North 35th Street
..... Room 168

Open Enrollment Fair

NOTE: When you select the United Healthcare (UHC) Choice Plan, there is no need to designate a primary care doctor for yourself and each member of your family. Access the online "Find a Physician" directory at www.UHC.com to determine if your Physician is within the United Healthcare (UHC) Choice Plan. The City cannot guarantee that your Primary Care Physician will be with UHC for the entire year.

When this booklet was printed the City had not established Health/Dental terms for the year 2011 with all employee groups. As a result the employee contribution levels on your Benefit Information Statement may change. The benefits structures may change during the calendar year based on current labor contract agreements.



➢ Notice to Employees Regarding the Thirty-Day Rule:

Active employees are responsible for keeping their enrollment status current. Login on the Internet to https://cmil.mycmsc.com then click HRM PRD on the left side. All employees must have their Employee ID number and a Password. To request or reset a password you can send an email to www.Milwaukee.gov/FMISpasswordhelp. You must enter the Life Event changes **within 30 days** of births, adoptions, marriages (including marriage to another City employee), divorces, dependents ceasing to be dependents, former dependents that become eligible dependents again, deaths. The social security number is required for each eligible dependent enrolling within the UHC plan. A copy of a marriage, birth and/or adoption certificate is required when enrolling an eligible dependent. There is no penalty for a City employee who waives coverage and takes coverage through a spouse or another health plan. New employees must enroll on the Self Service program within 30 days of their City start date and employees returning to work from layoff or any other reason must also enroll on the Self Service program within 30 days of their return-to-work date. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) **There will be no exceptions to this rule.**

➢ Notice to Employees regarding the One-Family Plan Rule:

City employees who are married to each other may only carry one health plan and one dental plan between them. One spouse may carry both health and dental plans, or one spouse may carry the health plan and the other spouse may carry the dental plan. You are required to report your marriage to another city employee within 30 days of the date of your marriage. There may be financial penalties if you fail to report your marriage.

City of Milwaukee Management employees whose spouse is employed by another governmental agency may only be enrolled in a family coverage with the City of Milwaukee or with their spouse's employer, but not both.

➢ Domestic Partners

Domestic Partner medical benefits are available for some employee groups. City employees must be in a registered Domestic Partnership in order to be eligible for these benefits. There are tax implications associated with the benefits. Call Employee Benefits at 286-2178 for information.

➢ Hospital Quality

The City understands the value of hospitals providing a high quality of care. There are several measures available for review of hospital quality. All the Milwaukee area hospitals are participating in both the Leapfrog and the Wisconsin Hospital Association Checkpoint plans, www.wicheckpoint.org. For information about Leapfrog hospitals data in WI, click on http://www.leapfroggroup.org/. .

DISCLAIMER:

Receiving this booklet does not necessarily imply you are eligible for City health and/or dental coverage. Only persons eligible under labor contract provisions, Common Council resolutions, or COBRA may enroll. In making these various plans available, the City of Milwaukee is not endorsing the selection of a particular plan or the level of benefits or quality of care offered by a particular plan. It is the responsibility of the employee to carefully review the plan and to make a decision based on this review. This material was prepared and sent with the cooperation of the City's health and dental plans.

BASIC HEALTH PLAN

The **Basic Health Plan**, administered by Anthem Blue Cross Blue Shield, is designed to provide in-patient hospital benefits, medical/surgical benefits and major medical benefits. By enrolling in the Basic Health Plan you are also enrolling in the Utilization Review/Case Management (UR/CM) program (see description below). If you have questions, call Anthem Blue Cross Blue Shield at 1-866-926-7789, the website www.Anthem.com.

HOSPITAL BENEFITS

Available for inpatient care (semi-private room) for each period of disability. All medically necessary in-patient hospital services, equipment, medications and supplies are provided. In-patient care is also provided for treatment of mental health and substance abuse. Outpatient coverage is provided for first aid emergency services, medical emergencies and treatment of mental health and substance abuse.

HEALTH IMPROVEMENT PLAN

(Disease Management)

Anthem offers a disease management program called the Health Improvement Plan (HIP). HIP offers an innovative, multidisciplinary approach to helping employees manage their **asthma, congestive heart failure** and **diabetes**. Program participants have experienced an increased quality of life and declined use of costly services. Through Health Coaching the goals are to **reduce patient anxieties about their condition and help them better manage their condition; identify areas of need and enhance appropriate use of the healthcare system; and reduce the need for emergency room visits and/or lengthy hospitalizations.**

Eligible participants are identified through routine reviews of submitted diagnosis and pharmacy codes in our claims system and then categorized as either high risk or low risk for one of the above three conditions. Employees or their dependents may also be referred to the program through a **hospital discharge report, a Physician or medical group referral, Case Management or by a self-referral by calling 1-866-387-8827. PARTICIPATION IS ALWAYS UP TO THE MEMBER.**

MAJOR MEDICAL

Covers 80% of the cost of most routine usual & customary medical expenses (if medically necessary), after the deductible has been satisfied $50.00 (retirees) per person, $150 per family maximum or $100.00 (active) per person, $300 per family maximum. Deductible will continue to accrue for three and more dependents until the third deductible has been reached. Refunds will be made for out-of-pocket expenditures above the third deductible. Coverage includes office visits and prescription drugs, as well as ambulance charges, private duty nursing, medical supplies, and a number of other items. See pg. 8 for information on the use of the City of Milwaukee Basic Health Plan Drug Plan, administered by Navitus Health Solutions, LLC.

UTILIZATION REVIEW/CASE MANAGEMENT (UR/CM)

The UR/CM Program administered by Anthem Blue Cross Blue Shield, is a cooperative effort by the City and its unions to improve the efficiency of health care delivery while maintaining the quality of care. This program does not shift health care costs to employees or reduce benefits. It does use medical resources in the most cost-effective manner by discouraging unnecessary hospitalizations and surgeries. Also included is a medical information service that can provide information about a wide variety of medical-related subjects. The UR/CM services include Continued Stay Review (monitoring of your continued treatment to assure that it is not longer than medically necessary), Second Surgical Review and Discharge Planning. If you have questions, call Anthem Blue Cross Blue Shield at 1-800-860-4885.

Additional information about the UR/CM program will be available at the Basic Plan (Anthem Blue Cross Blue Shield) table during the Open Enrollment Fairs or by calling Employee Benefits at (414) 286-3184, Anthem Blue Cross Blue Shield at 1-866-926-7789.

MAJOR COMPONENTS OF THE ANTHEM BLUE CROSS BLUE SHIELD UTILIZATION REVIEW/CASE MANAGEMENT

The UR/CM program covers all City employees, Retirees, Disability Retirees, Surviving Spouses, COBRA enrollees and all dependents for which the City's Basic Plan is prime. **This program will not cover persons for whom Medicare is prime. Pre-authorization is required for all inpatient hospital admissions** (and emergency hospital admissions within 48 hours of the admission). **A PENALTY MAY BE IMPOSED IF ANTHEM BLUE CROSS BLUE SHIELD IS NOT NOTIFIED ON A TIMELY BASIS.**

Frequently Asked Questions (FAQ) about your City of Milwaukee Pharmacy Benefit Manager (PBM) Drug Plan, Administered by Navitus Health Solutions, LLC

(Enrollees in the Basic Plan and United Healthcare Choice Plan)

About Navitus Health Solutions

➢ **What is Navitus? What is a pharmacy benefit manager?**

Navitus Health Solutions is your pharmacy benefit manger (PBM). Navitus provides pharmacy benefit management services for a variety of organizations including health plans and self-funded employer groups. Navitus Health Solutions is committed to lowering drug costs, improving health and delivering superior service in a manner that inspires trust and confidence.

A pharmacy benefit manager (PBM) is a third party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims. In addition, a PBM typically negotiates discounts and rebates with drug manufactures, contracts with pharmacies, and develops and maintains the formulary.

ID card for Pharmacy Benefits

➢ **Can I use my health plan card to fill prescriptions at my pharmacy?**

No. All City employees will get a separate card for their prescription drugs. Please use the Navitus Health Solution ID card to fill your prescriptions.

Which medications are covered?

➢ **What is a formulary and how is it developed?**

Your formulary (pronounced FOR-mew-lerr-ee) for the UHC Choice Plan is a list of drugs covered as part of your pharmacy benefit. It is developed by medical and pharmacy experts. The use of a formulary helps to ensure that your health care professional selects medications for you that are safe, effective and affordable.

The Basic Plan does not have a formulary but does have a 20% co-insurance.

The Pharmacy and Therapeutics (P&T) Committee first reviews medications based on their therapeutic value, effectiveness and the side effects of the medication. After determining which drugs are comparable, the committee looks at the cost in comparison to similar medications. On a continuous basis, new and existing drugs are reviewed to make sure the formulary is kept up-to-date and that patient needs are being met.

➢ **Do some prescription drugs require prior authorization from Navitus?**

Yes. Navitus has identified a limited number of prescription drugs that require prior authorization. Prior authorization is initiated by the prescriber on behalf of the member. More information about which medications require prior authorizations, as well as the prior authorization process is available on the Navitus website, www.navitus.com. Medications that require prior authorizations for coverage can be identified on your formulary documents by a notation of PA. Navitus will review the prior authorization request within 48 hours of receiving complete information from your health care professional.

Some UHC members will have the Two Tier, $4 generic and $8 formulary brand drugs co-payment. Non-formulary drugs are not covered. Employees with the current contracts and UHC have a Three Tier drug formulary, $5, $17 and $25. There are drugs that are not covered under the Three Tier formulary.

Filling Prescriptions at a Pharmacy

➢ **With Navitus, can I continue to use my regular pharmacy? Where can I obtain a listing of pharmacies covered under Navitus?**

In most cases you will be able to continue to use your current pharmacy and, as a result of Navitus' affiliation with other pharmacies in the state and across the nation, you may have more opportunities to use a variety of pharmacies of your choice. Listing of national and local pharmacies within the Navitus network is available on the Navitus website, www.navitus.com. Members may also contact Navitus Customer Care toll-free at (866) 333-2757 to determine if a specific pharmacy is covered or for more information about the Navitus pharmacy network.

➢ **When can I refill my prescription?**

Prescriptions can be refilled when 70% of the original days supply is used. Early refills (before 70% is used) in excess of what is prescribed, or refills dispensed after one year from the initial prescription order are not covered.

Definitions of Commonly Used Terms

Brand/Generic drugs are defined by MediSpan (or similar organization). Medispan is a national organization that determines brand/generic drug classifications. Drugs that are approved by the Federal Drug Administration (FDA) and accepted by medical professionals.

Co-payment/Coinsurance refers to that portion of the total prescription cost that is a financial responsibility of the member for each prescription order.

Generic Equivalents means prescription drugs that contain the same active ingredients, same dosage form and strength as its brand name counterpart.

Mail Order Pharmacy Services allow members to obtain maintenance medications without physically visiting a pharmacy. Mail order often allows members to obtain more than a one-month supply of medication at one time. Mail order services are provided by Prescription Solutions, the website www.Prescriptionsolutions.com 1-800-908-9097.

Over-the-Counter Medication means medication that can be purchased without a prescription order.

Prescription Drug means any medicinal substance, the label of which, under Federal Food, Drug and Cosmetic Act is required to bear the legend: "Prescription only.

Prior Authorization means obtaining approval from Navitus in order for coverage to apply.

Therapeutic Equivalent means similar drug in the same drug classification used to treat the same condition.

City of Milwaukee to initiate Comprehensive Health & Wellness effort for Employees & Spouses

The City of Milwaukee has contracted with Froedtert and Community Health Workforce Health to provide a comprehensive health and wellness services to City employees. The program will begin in late 2010. The program will include a blood draw, an online Health History (38 questions), measurements, a meeting with one of Workforce Health's health educators and a report to each member who completes the process. Employees who complete the comprehensive health and wellness service will have lower monthly health insurance premiums.

Additional services, including smoking cessation classes, will be available to City employees. More information about this program will be sent to each employee. Representatives from Workforce Health will be at the City of Milwaukee Open Enrollment Fairs. This program is being initiated by the City and the City unions to assist employees in maintaining their good health.

City of Milwaukee Diabetic Benefits for Actives

Diabetic Claims (Equipment and Supplies) Claims Adjudication Processes

Non-Medicare Actives	
Item	**Claim Adjudication**
Durable Medical Equipment (DME) to include insulin pumps and the supplies used for insulin pumps.	Processed through the medical benefit • **UHC Choice**: processed at 100% through in-network DME provider • **Basic Plan** administered by Anthem processed at 80% of usual and customary costs through any DME provider
Diabetic testing supplies to include test strips, meters, lancets, etc.	Processed through the pharmacy benefit (Navitus). • UHC Choice Members have a three tier drug plan, $5, $17, $25 through Navitus Members with • Basic Plan Members administered by Anthem have a 20% co-insurance through Navitus Meters are available at no charge to the member.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE: These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. The Basic Plan and United Healthcare Benefits are always subject to medical necessity

BENEFIT	CITY OF MILWAUKEE Basic Plan (Administered by Anthem Blue Cross Blue Shield). Services may be subject to Utilization Review for medical necessity.	CITY OF MILWAUKEE United Healthcare (UHC) Choice Plan *Current Contracts* *Those groups that settle their contracts late in 2010 or in 2011 can expect a premium and benefit change.*	UNIFORM BENEFIT PLANS United Healthcare (UHC) Choice Plan *Old Contracts* *Be sure to check with UHC to determine if specific treatments are covered.* *The benefits structure can be subject to change based on a labor agreement and may change during the calendar year.*
1. Hospitalization	100% of usual & customary charges covered. Additional benefits may be available under Major Medical.	Benefit is 100%.	Benefit is 100%.
2. Surgical Medical Care	100% of usual & customary charges of physician.	Benefit is 100%.	Benefit is 100%.
3. Physician visits in Hospital	100% of usual & customary charges covered.	Benefit is 100%.	Benefit is 100%.
4. Maternity	Semi-private hospital room charges paid. Pays usual & customary charges of physician (dependent daughters covered).	Benefit is 100%.	Benefit is 100%.
5. X-Ray and Lab Tests (including Routine)	100% of usual & customary charges covered.	Benefit is 100%.	Benefit is 100%.
6. Radiation Therapy	100% of usual & customary charges covered.	Benefit is 100%.	Benefit is 100%.
7. Emergency Room **A. Accident (in or out of area)** **B. Illness (in or out of area)**	100% of usual & customary charges covered. No maximum. If final diagnosis indicates such treatment was necessary-usual & customary charges covered.	Member may have $50 Emergency Room co-pay for accident or illness.	Member has $25 Emergency Room co-pay for accident or illness **UNLESS** the patient is admitted to the hospital **OR** the patient's physician referred the visit.
8. Physician Office Visits & Urgent Care Visits	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Member has a $10 co-pay for all office and urgent care visits due to illness or injury	No deductible, co-pay, or co-insurance. Includes charges for routine office visits, well baby care visits, health education and counseling, hearing exams, family planning advice, and nutritional counseling from a primary care or specialty physician or members of their staff billed by the physician.

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BENEFIT	CITY OF MILWAUKEE Basic Plan (Administered by Anthem Blue Cross Blue Shield). Services may be subject to Utilization Review for medical necessity.	CITY OF MILWAUKEE United Healthcare (UHC) Choice Plan *Current Contracts* ***Those groups that settle their contracts late in 2010 or in 2011 can expect a premium and benefit change.***	UNIFORM BENEFIT PLANS United Healthcare (UHC) Choice Plan *Old Contracts* ***Be sure to check with UHC to determine if specific treatments are covered.*** ***The benefits structure can be subject to change based on a labor agreement and may change during the calendar year.***
9. Major Medical Care			
A. Yearly Deductible	$100 per person - $300 per family maximum.	Not Applicable.	Not Applicable.
B. Coinsurance/Co-payment	80% Covered, 20% paid by subscriber.	Information noted next to each benefit plan.	Information noted next to each benefit plan.
10. Chiropractor Office Visits	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is 100%.	Benefit is 100%.
11. Physical Therapy, Speech Therapy & Occupational Therapy	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is payable for up to 50 visits per calendar year for **EACH** type of medically necessary therapy.	Benefit is payable for up to 50 visits per calendar year for **EACH** type of medically necessary therapy.
12. Immunizations & Injections	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is payable for medically necessary injections or immunizations, including hormones. Benefit is 100%.	Benefit is payable for medically necessary injections or immunizations, including hormones. Benefit is 100%.
13. Durable Medical Equipment	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit includes 20% co-insurance, up to a maximum of $500 per member per calendar year for durable medical equipment, prosthetics and orthotics combined. Covered services include, but are not limited to, the initial acquisition of artificial limbs and eyes, cast, splints, trusses, crutches, orthopedic braces and appliances, ostomy supplies, compression hose for appropriate diagnoses, wheelchairs, hospital type beds, and artificial respiration equipment, therapeutic lenses, and initial cataract lenses.	Benefit includes 20% co-insurance, up to a maximum of $500 per member per calendar year for durable medical equipment, prosthetics and orthotics combined. Covered services include, but are not limited to, the initial acquisition of artificial limbs and eyes, cast, splints, trusses, crutches, orthopedic braces and appliances, ostomy supplies, compression hose for appropriate diagnoses, wheelchairs, hospital type beds, and artificial respiration equipment, therapeutic lenses, and initial cataract lenses.
14. Prescription Coverage (including oral contraceptives)	**Retail** Covered at 80% under major medical for a 30-day supply. A select list of over-the-counter (OTC) medications are covered within the Navitus formulary. Additionally, the following four OTCs are covered as well; Zyrtec (cetirizine), Claritin (loratadine), Alavert, and Niacin. **Mail Order** For additional savings, Mail Order will provide a three months (90 days) supply for a two months (60days) coinsurance on most maintenance drugs.	There is a three-tier drug plan. Tier 1 drugs have a $5 co-pay. Tier 2 drugs have a $17 co-pay and Tier 3 drugs have a $25 co-pay. A select list of over-the-counter (OTC) medications are covered within the Navitus formulary. Additionally, the following four OTCs are covered as well; Zyrtec (cetirizine), Claritin (loratadine), Alavert, and Niacin. There are non-covered drugs that are on the three tier formulary. **Mail Order** For additional savings, Mail Order will provide a three months (90 days) supply for a two months (60days) co-pay on most maintenance drugs.	Drugs and biologicals co-pay $4.00 generic and $8.00 brand for 30-day supply. Brand name co-pay applies if no generic is available. Member requested brand name drugs are subject to the brand co-pay **PLUS** the difference between the generic and the brand name drug. ***Prescription Coverage administered by Navitus Health Solutions.***

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	There is no out of pocket maximum for retail or mail order prescription drugs. ***Prescription Coverage administered by Navitus Health Solutions.***	***Prescription Coverage administered by Navitus Health Solutions.***	
15. Allergy Care	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is 100%.	Benefit is 100%.
16. Mental Health and Substance Abuse, Drug and Alcohol Abuse	Benefit includes outpatient hospital services, inpatient hospital services and transitional care as medically necessary. Professional office visits covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit includes outpatient hospital services, inpatient hospital services and transitional care as medically necessary. Member has a $10 co-pay for professional office visits.	Benefit includes outpatient hospital services, inpatient hospital services and transitional care as medically necessary. Member has a $10 co-pay for professional office visits.
17. Organ Transplants	All non-experimental and non-investigational care related to transplant is covered as limited by the plan, including donor searches/procurements and private duty nursing.	Benefit is 100% when the United Resource Network (URN) Organ Transplant Network is utilized. Drug co-pay applies for transplant related drugs. Covers heart, heart/lung, liver, lung, kidney, kidney/pancreas, bone marrow, parathyroid, and musculo/skeletal.	Benefit is 100% when the United Resource Network (URN) Organ Transplant Network is utilized. Drug co-pay applies for transplant related drugs. Covers heart, heart/lung, liver, lung, kidney, kidney/pancreas, bone marrow, parathyroid, and musculo/skeletal.
18. Ambulance	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit for surface ambulance is payable in full for the first $300; charges in excess of $300 is payable at 80%. Benefit for air ambulance is payable in full for the first $1,000; charges in excess of $1,000 are payable at 80%. ***Co-insurance is waived for approved hospital-to-hospital transfers.***	Benefit for surface ambulance is payable in full for the first $300; charges in excess of $300 is payable at 80%. Benefit for air ambulance is payable in full for the first $1,000; charges in excess of $1,000 are payable at 80%. ***Co-insurance is waived for approved hospital-to-hospital transfers.***
19. Private Duty Nursing	Covered at 80% usual & customary charges under major medical after deductible is satisfied	Benefit for home health care is limited to 50 visits per calendar year	Benefit for home health care is limited to 50 visits per calendar year.
20. Oral Surgery	*13 specific oral surgical procedures provided, including gingivectomy, alveolectomy & apicoectomy covered at 80% under major medical after deductible is satisfied	* Benefit is limited to 13 specific oral surgical procedures, including gingivectomy, alveolectomy & Apicoectomy. A United Healthcare network provider must be used.	* Benefit is limited to 13 specific oral surgical procedures, including gingivectomy, alveolectomy & Apicoectomy. A United Healthcare network provider must be used.
21. TMJ Treatment	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is limited to 80% of charges related to diagnosis and treatment of TMJ dysfunction syndrome for the following: - Physician and specialist consultation	Benefit is limited to 80% of charges related to diagnosis and treatment of TMJ dysfunction syndrome for the following: - Physician and specialist consultation

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		- rehabilitative therapy services including TENS therapy - adjustment of corrective appliances - charges for the fitting and installation of corrective splints. - maximum benefit payable of $1250 per year. A United Healthcare network provider must be used.	- rehabilitative therapy services including TENS therapy - adjustment of corrective appliances - charges for the fitting and installation of corrective splints. - maximum benefit payable of $1250 per year. A United Healthcare network provider must be used.
22. Skilled Nursing Home Care (after hospitalization)	30 days per disability under basic benefits at 100%. An additional 90 days under major medical benefits at 80% usual & customary charges after the deductible is satisfied.	Benefit for skilled nursing care for maximum of 120 days per inpatient stay.	Benefit for skilled nursing care for maximum of 120 days per inpatient stay.
23. Hospice Care	COVERED at 100%.	Hospital or home hospice care covered, depending on the decision of the individual's primary care physician. Benefit is 100%.	Hospital or home hospice care covered, depending on the decision of the individual's primary care physician.
24. Vision Care	NOT COVERED	Benefit is for routine vision care annual exam including the prescription of eyewear at UHC vision network facilities. No coverage for eyeglasses or contact lenses. Discounts for eyeglasses or contact lenses are available under the UHC STANDARD VISION Program at 1-877-426-9300.	Benefit is for routine vision care annual exam including the prescription of eyewear at UHC vision network facilities. No coverage for eyeglasses or contact lenses. Discounts for eyeglasses or contact lenses are available under the UHC STANDARD VISION Program at 1-877-426-9300.
25. Physicians' Charges for Preventive Care Services including Well Baby Care	Well Baby Care Visits covered at 100%, all other charges covered at 80% usual & customary charges.	Benefit is 100%.	Benefit is 100%.
26. Hearing Exams	Covered at 80% after deductible is satisfied. Under major medical when there is a medical condition (not for the purpose of prescribing hearing aids).	Benefit is covered only if performed by primary care physician or approved specialty physician.	Benefit is covered only if performed by primary care physician or approved specialty physician.
27. Hearing Aids	For enrolled dependent children under age 18, benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law.	For enrolled dependent children under age 18, benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law.	For enrolled dependent children under age 18, benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law.
28. Nutritional Counseling	Nutritional counseling for the treatment of morbid obesity is covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is covered when medically necessary. Benefit is 100%.	Benefit is covered when medically necessary. Benefit is 100%.
29. Infertility Services (Diagnosis of	NOT COVERED. Diagnostic services covered at	No benefits for services primarily for the purpose	No benefits for services primarily for the purpose

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE: These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. The Basic Plan and United Healthcare Benefits are always subject to medical necessity

BENEFIT	CITY OF MILWAUKEE Basic Plan (Administered by Anthem Blue Cross Blue Shield). Services may be subject to Utilization Review for medical necessity.	CITY OF MILWAUKEE United Healthcare (UHC) Choice Plan *Current Contracts* *Those groups that settle their contracts late in 2010 or in 2011 can expect a premium and benefit change.*	UNIFORM BENEFIT PLANS United Healthcare (UHC) Choice Plan *Old Contracts* *Be sure to check with UHC to determine if specific treatments are covered.* *The benefits structure can be subject to change based on a labor agreement and may change during the calendar year.*
Infertility)	80%, only. Treatment and prescription drugs are not covered.	of treating or reversing infertility or for artificial insemination services including donor service or other forms of fertilization including prescription drugs for infertility.	of treating or reversing infertility or for artificial insemination services including donor service or other forms of fertilization including prescription drugs for infertility.
30. Physical Fitness	NOT COVERED	NOT COVERED	NOT COVERED
31. Home Health Care	Up to 40 visits per year when medically necessary under basic benefits. An additional 40 days under major medical covered at 80% per calendar year after the deductible is satisfied.	Benefit for home health care is limited to 50 visits per year.	Benefit for home health care is limited to 50 visits per year.
32. Dependent Coverage	Include employee's spouse; eligible dependent children, stepchildren, foster children, grandchildren (if the parent is an eligible dependent child under the age of 18), adopted children and children placed for adoption as mandated by the State or Federal government. Based on the recent federal health care reform, coverage for dependent children is through the end of the calendar year in which the dependent child or adult child turns 26, without regard to the adult child's school status, marital status or dependent status. There will be state imputed tax only, not federal imputed tax, if the adult child is not an IRS dependent. Based on current state law the adult child is eligible for coverage through the end of the month the child turns 27. If the adult child has turned 26 in the previous year the adult child can be covered until the end of the month they turn 27 but with both federal and state imputed tax.		
Policy Deductible	$100 per person - $300 per family	NONE	NONE

"UNIFORM BENEFITS" does not mean that each UHC Choice Plan or all providers will treat all illness in the same manner from year to year. Nor does it require that each and every service be identically covered. The UHC Choice Plan retains the right to substitute services in such a manner as to maintain quality care of the patient. However, maximums, deductibles, co-payment amounts or co-insurance specified in this document cannot be altered. Treatment will vary based on the needs of the patient, the physicians involved and the managed care policies and procedures of each insurance plan.

NOTE: In 2011 UHC Choice Plan will offer two benefit structures based on current labor contracts. Both are summarized above. The benefit structure may be subject to change during the calendar year based on labor contracts.

The **"LIFETIME LIMIT"** on the dollar value of benefits under the Basic Plan administered by Anthem and the United Healthcare Choice Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the City of Milwaukee, Employee Benefits Division at 414-286-3184.

*** United Healthcare & Anthem Oral Surgery is limited to the following 13 oral surgical procedures** (see #20 above)**:**

1. Surgical removal of bony impacted teeth;
2. Excision of tumors, cysts of the jaws, cheeks, lips, tongue, roof of mouth when such conditions require pathological examination;
3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of mouth;
4. Apicoectomy;
5. Excision of exostosis of jaws and hard palate;
6. Treatment of fractures of facial bones;
7. External incisions and drainage of cellulitis;
8. Incision of accessory sinuses, salivary glands or ducts;
9. Gingivectomy;
10. Alveolectomy;
11. Frenectomy;
12. Removal of retained root;
13. Gingival and Apical curettage.

CITY OF MILWAUKEE DENTAL PLAN COMPARISON CHART

(Retirees are not eligible for Dental Coverage)

NOTE: These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts.

	CARE+PLUS PREPAID	**DENTALBLUE** WI Dentacare Standard Network	**CITY WPS/DELTA DENTAL PLAN** [6]		
			Police	Fire	General
ANNUAL MAXIMUM	Unlimited	Unlimited	$1,000	$1,000	$1,000
DEDUCTIBLE **Single** **Family**	 None None	 None None	 $25 $75	 $25 $75	 $25 $75
DIAGNOSTIC **Oral Exam, X-Rays**	 Covered	 Covered	 You Pay 20%	 You Pay 20%	 Covered[1]
PREVENTIVE **Cleaning** **Fluoride (2x/yr)** **Sealants (2x/yr)**	 Covered Covered-age 18[2] Covered-age 15[2]	 Covered Covered-age 15[2]	 You Pay 20% Covered-age 18[2]	 You Pay 20% Covered-age 18[2]	 Covered[1] Covered-age 18[2]
RESTORATIVE **Fillings**[3] **Crowns**[4]	 Covered Covered[4]	 Covered Covered[5]	 You Pay 20% You Pay 20%	 You Pay 20% You Pay 20%	 You Pay 20% You Pay 20%
PROSTHODONTICS **Bridges, Dentures** **Implants**	 Covered[4] Not Covered	 Covered[5] Not Covered	 You Pay 20% You Pay 20%	 You Pay 20% You Pay 20%	 You Pay 20% You Pay 20%
PROSTHETICS **Denture Repairs**	 Covered	 Covered	 You Pay 20%	 You Pay 20%	 You Pay 20%
ORAL SURGERY[6] **Simple Extractions**	 Covered	 Covered	 You Pay 20%	 You Pay 20%	 You Pay 20%
ENDODONTICS **Root Canals**	 Covered	 Covered	 You Pay 20%	 You Pay 20%	 You Pay 20%
PERIODONTICS[6] **Treatment of Gums & Tissue**	 Covered	 Covered	 You Pay 20%	 You Pay 20%	 You Pay 20%
ORTHODONTICS **Maximum Plan will pay** **Employee Co payment**[7] **Deductible** **Dependent Age Limit** **Invisalign Braces** **Expected co-pay on $5,000 Treatment Plan**	 None 50% up to $750 None None Not Covered You Pay $750	 None 50% up to $750 None None Not Covered You Pay $750	 $2,000 40% up to $3333 100% over $3333 $25 25[8] Covered You Pay $3000	 $1,000 40% up to $1666 100% over $1666 $25 19[8] Covered You Pay $4000	 $1,200 50% up to $2000 100% over $2000 $25 25[8] Covered You Pay $3800

NOTES:

1. **Covered at 100% of "maximum plan allowance" or the total dollar amount allowed for each dental procedure code.**
2. **Coverage may extend beyond age limit indicated if part of a Periodontal Treatment Plan.**
3. **White composite on posterior teeth may be subject to co-payments and/or covered at a lesser percentage than indicated.**
4. **Covered with base or noble metal. High noble metal is extra.**
5. **Only base metal covered. Noble or high noble metal and related lab fees are subject to co-payments. Many dentists only use noble metals. Ask your provider to document your out-of-pocket expense prior to initiating treatment.**
6. **Does not duplicate medical coverage.**
7. **A new co-payment will be assessed should you change dental plans during orthodontic treatment. Care+plus may reduce the required co-payment for transferring ortho-in-treatment patients based on treatment previously received and remaining length of treatment.**
8. **Employee and spouse are not subject to age limit indicated.**

Care+Plus has two clinics. They are located at 1135 S. Cesar Chavez Drive and 11711 W. Burleigh Street in Milwaukee. You do not need to specify a clinic preference when enrolling and may use the clinics interchangeably. To visit the Care+Plus website, navigate to: www.dentalassociates.com.

Delta Dental covers the dentist of your choice. You do not need to select a clinic or provider as part of enrollment, and may switch dentists at will. Family members can utilize different clinics and clinicians. By choosing a Delta Dental provider you will receive a discount on the cost of dental services.

The Delta Dental Provider Directory may be found on the City's website at:
http://www.milwaukee.gov/ImageLibrary/User/jkamme/EmployeeBenefits/DeltaDental_Directory.pdf

To visit the Delta's website, navigate to: www.deltadentalwi.com.

DentalBlue clinics are located throughout the metropolitan area. You must select a clinic from the Anthem Dentacare Standard Provider Directory and indicate a 12 digit clinic/provider code during enrollment. Choose your provider thoughtfully. **DentalBlue does not allow clinic changes outside of open enrollment and will not pay for treatment rendered at a clinic other than the one you select.** Family members are required to use the same clinic although they may see different dentists within the clinic.

The DentalBlue Provider Directory is on the City's website at:
http://www.milwaukee.gov/ImageLibrary/User/jkamme/EmployeeBenefits/DentalBlue_Directory.pdf

and available at:
http://www.Anthem.com (Select "WI" and "DentalBlue-Dentacare Standard Network," then designate your search parameter.)

Be there for the people you care about

For Open Enrollment questions, please call 1-866-926-7789

www.anthem.com

Anthem

Lighting the way to better health

As the pharmacy benefit manager for the City of Milwaukee's Health Plans, Navitus Health Solutions is dedicated to providing the best possible care at the lowest possible cost. We light the way to better health by providing world-class customer service and offering programs and services aimed at supporting the health care needs of you and your family.

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24-hour NurseLine℠ services make it easy to connect to the right care

- Help from a live registered nurse by phone anytime
- Get doctor and appointment recommendations with personal follow-ups
- See if the emergency room, a doctor visit or self-care is right for your needs
- Learn more about a diagnosis
- Search for doctors based on your needs and preferences
- Find hospitals that meet UnitedHealthcare's quality standards
- Explore the risks, benefits and possible outcomes of your treatment options
- Learn how to take medication safely and avoid interactions

For informational purposes only. NurseLine℠ nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued at any time. For a complete description of the UnitedHealth Premium® Designation program, including details on the methodology used, geographic availability, program limitations and medical specialties participating, please see myuhc.com®.

It's never been easier to get quality care

We have high standards for the doctors in our network, anyway. But to recognize the doctors who have a proven track record for delivering quality care that keeps patients from needing further treatments – and to make sure our members can find them easily, we created the UnitedHealth Premium® designation program. It evaluates and recognizes physicians who meet national industry standards for quality care and local market benchmarks for cost efficiency.

Visit myuhc.com® to begin your search. All you have to do is look for the stars.

Step 1: Go to myuhc.com.
Step 2: Click Find a Physician or Facility.
Step 3: Select Search for a Physician and click Continue.
Step 4: Select Search for UnitedHealth Premium Physician and fill out your name/location/plan. Click Continue.
Step 5: Select any specialties you need. Click Continue.
Step 6: Browse the list to find the 2-star doctor best suited to your needs.

The simplest solution of all: creating plans packed with value and quality

To make it even easier for you to pick a plan that works for you, all of our plans are packed with the right combination of benefits, value, options and extras. Suddenly, shopping for health care coverage just got simpler.

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Healing health care. Together.®

Bringing HEALTH *to* Work.

We are proud to deliver the City of Milwaukee's wellness program to you. Please look for important details in the mail at the end of September that explain the benefits for participating in the program. To find out who we are, visit ***workforcehealth.org.***

Froedtert HEALTH
Workforce Health

Workforce Health works with progressive organizations who want to make health a key business initiative. They recognize the health of their workforce as an economic imperative, and partner with us to improve the health of their employees.

Our programs and services are customized to meet the needs of employers and employees. Based on the company's aggregate HRA data, we are able to create an overall company health profile. We'll work with the company to design a wellness plan that best fits their employees' needs and resources to improve health.

Our benefit services team, based in Wisconsin, averages nine years of experience at Delta Dental of Wisconsin. To find out more about Becky and her team visit: **experience.deltadentalwi.com**

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Rickey Moore, patient, and Dr. Donald C. Gundlach

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Dental Blue — giving employees something to smile about.

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Anthem

Notice to Enrollees in the City of Milwaukee's Nonfederal Governmental Group Health Plan

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans beginning with plan year anniversary dates after June 30, 1997. Other requirements apply beginning with plan year anniversary dates occurring on or after January 1, 1998. HIPAA provides that the plan sponsor of a self-funded nonfederal governmental plan may elect to exempt the plan from any or all of the following requirements:

1. **Limitations on preexisting condition exclusion periods**.
   A preexisting condition exclusion period may not exceed 12 months, and must be reduced, under certain circumstances, by prior medical benefits coverage an individual has had.
2. **Special enrollment periods**.
   Group health plans are required to provide a 30-day special enrollment period for individuals and dependents that do not enroll in the plan at the first opportunity because they have other coverage and subsequently lose that coverage. Also, if a plan provides dependent coverage and a person becomes a dependent through marriage, birth, adoption or placement for adoption, the plan must provide a special enrollment period of not less than 30 days.
3. **Prohibitions against discriminating against individual participants and beneficiaries based on health status**. A group health plan may not establish enrollment rules (including continued eligibility) for an individual based on any of the following health status-related factors:
   - medical condition (physical and mental illnesses)
   - claims experience
   - receipt of health care
   - medical history
   - genetic information
   - evidence of insurability
   - and disability
4. **Standards relating to benefits for mothers and newborns.**
   (Effective for plan years beginning on or after January 1, 1998). Group health plans offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for mother and child for a minimum period of time, generally 48 hours for a normal vaginal delivery, and 96 hours for a cesarean section.
5. **Parity in the application of certain limits to mental health benefits.**
   (Effective for plan years beginning on or after January 1, 1998). Group health plans offering mental health benefits may not set annual or lifetime limits on mental health benefits that are lower than limits for medical and surgical benefits. A plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose a limit on mental health benefits. These requirements do not apply to benefits for substance abuse or chemical dependency.

The City of Milwaukee has elected to exempt its Basic Health Plan from all of the above requirements. The City of Milwaukee's Basic Health Plan currently voluntarily provides certain benefits similar to requirements 1, 2 (with respect to dependent coverage only), 3 and 4 above.

The exception from these Federal requirements will be in effect for the plan years beginning January 1, 2011 and ending December 31, 2012.

Any questions concerning this notice may be directed to:

Employee Benefits Director
200 E. Wells St., City Hall, Room 706
Milwaukee, WI 53202
(414) 286-3184

This notice is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that group health plans (including the City of Milwaukee Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including: open enrollment and special enrollment rights. Specific information describing continuation coverage can be obtained from the Department of Employee Relations, Employee Benefits, 200 East Wells, Milwaukee, WI 53202, 414-286-2047, attention: Crystal Owens.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the City of Milwaukee Employee Benefits of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the City of Milwaukee Employee Benefits of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the City of Milwaukee Employee Benefits of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the City of Milwaukee Employee Benefits within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

When and how must payment for continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the City of Milwaukee Employee Benefits to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:
City of Milwaukee Employee Benefits
200 East Wells Street, Room 706
Milwaukee, WI 53202

Periodic payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:
City of Milwaukee Employee Benefits
200 East Wells Street, Room 706
Milwaukee, WI 53202

Grace periods for periodic payments
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days (or enter longer period permitted by Plan) to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.
If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?
Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visits the EBSA web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Flexible Choices Program

The City of Milwaukee is pleased to offer you the Flexible Choices Program, administered by **eflexgroup, Inc.** A Flexible Spending Account (FSA) is an important part of your overall benefit package. Through the Flexible Choices Program, you can set aside a portion of your earnings with pre-tax dollars, for everyday expenses you may have with dependent **day care expenses**, out-of-pocket **medical expenses**, including dental, vision, over-the counter medications, and prescription drug expenses and **work-related parking expense** FSA.

The Open Enrollment period is the proper time to enroll in the Flexible Choices Program for the first time or to renew your enrollment for the New Year. Remember, your Flexible Choice enrollment **does not roll over** into the New Year automatically, **you must re-enroll.** This program allows you to pay for your out-of-pocket medical, dependent care & work-related parking expenses with pre-tax dollars by designating a pre-set amount to be deducted from your paycheck each pay period before any taxes are computed.

See the enclosed program material for additional information.

Special Notice to all City Employees, Retirees and their Families

Women's Health and Cancer Right Act Notice
Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of mastectomy.

The City of Milwaukee health plans comply with these requirements. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The City of Milwaukee health plans do not impose penalties (for example, reducing or limiting reimbursements) and do not provide incentives to induce attending providers to provide care inconsistent with these requirements.

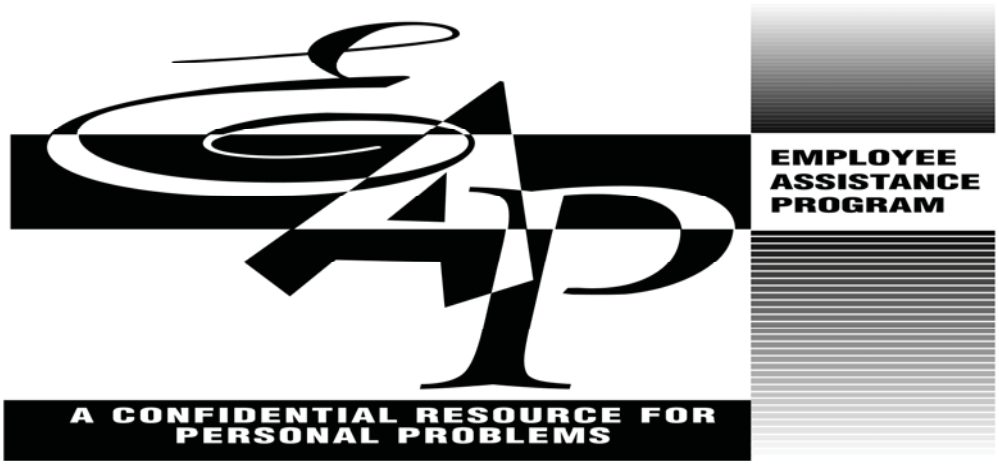
Questions, call the Employee Benefits Office at (414) 286-3184.

Group Life Insurance Certificate

General City, Fire and Police employees receive life insurance benefits through the Employes' Retirement System. If you want a copy of the Group Life Insurance Certificate for your records, go to:
http://www.cmers.com/cmers/DOCS/Forms/Final_Certificate.pdf

or

www.cmers.com
on the left side **click** Benefits and Forms
click Life Insurance
In the middle of the page, **click** Group Life Insurance Certificate,
and again in the middle of the page **click** Group Life Insurance Certificate.



What is The EAP?

The *Employee Assistance Program* (EAP) is a ***free*** and ***confidential*** counseling and referral service for all employees (full and part time/elected and appointed, union and non-union) and their eligible dependents that may be experiencing personal or workplace problems.

Who Operates The EAP?

The City's EAP is operated by the City of Milwaukee Department of Employee Relations with the assistance of a joint labor/management steering committee. A full time EAP coordinator is available to provide confidential consultation and referral.

What Types of Problems Does The EAP Handle?

The EAP handles a wide range of concerns. This includes but is not limited to:

Emotional	***Family Issues***
Stress	***Financial Concerns***
Legal Problems	***Substance Use***

What Other Services are Available?

The EAP also provides direct service to the City in the form of:

Workplace Consultations	***Information and Education***
Trainings/Workshops	***Policy Consultation***
Program Implementation	***Critical Incident Management***

How Do I Contact the EAP?

For more information, a consultation or to set up an EAP appointment, contact the EAP Coordinator, Monday through Friday 8:00am to 4:45pm at 414-286-3145.

For more EAP information, please visit the EAP website at:

http://www.milwaukee.gov/der/EAP

How To Enroll

SELF-SERVICE PROGRAM

1) The login Internet address is https://cmil.mycmsc.com then click HRMS PRD which is on the left side. In order to access the Self-Service Program, all Active employees must have their Employee ID Number and a Password. You will need the Employee ID/User ID Number and a Password in order to access the web browser either from home or work. To request or reset a Password you can send an email to www.Milwaukee.gov/FMISpasswordhelp.
   a) The Employee ID Number which is a six-digit number and you can find this number on your payroll statement at the top of the middle column above the Department's name.
   b) If you are in the Basic Plan, UHC, WPS/Delta Dental, Dental Blue or Care Plus Benefit Plans and do not want to change, you **do not** need to do anything.
2) If you add or delete a dependent(s):
   a) Please see the information as indicated above.
   b) All eligible dependent names must be capitalized.
   c) Place a check (☑) next to the box for all dependent(s) as a STUDENT. The Social Security Number for all eligible dependents will be required for the UHC plan.
3) If you do not want health or dental coverage, the "WAIVER FORM" is available to download at www.Milwaukee.gov/der. The waiver form must be sent to the Department of Employee Relations, City Hall, Room 706. There is no penalty for an employee who waives coverage and takes coverage through a spouse or another health plan.

Active Employees Making A Health/Dental Plan Change for the Year 2011

All Active employees Self-Service enrollment elections must be submitted by 10:59 p.m. on **Friday, October 29, 2010**.

The City continues to offer the Basic Plan and the United Health Care (UHC) Choice Plan in 2011.

Self-Service Instructions

Instructions
City of Milwaukee
Human Resources Management System
Employee Self Service Program

All Active employees will use the Self Service program to change your Health, Dental, Flexible Choices, Long Term Disability and Life Insurance benefits:

Login on the Internet to:
https://cmil.mycmsc.com, then click HRMS PRD on the left side.

Log into the Self Service Program

1. Enter your User ID. The User ID can be located on the Benefit Information Statement next to the Employee ID information. Enter your Password. If you do not remember your password **and have not set up the "forget your password"** option, please log into the Milwaukee Intranet "MINT." And click ITMD ASSISTANCE or send an e-mail to www.Milwaukee.gov/FMISpasswordhelp to request or reset a password.
2. Click the Sign In button. If this is your first time logging into the Self Service program, please set up the "Forget your password" option. Click Save. You are now set up to have a new password e-mailed to you when you "forget your password"

Health Insurance

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the Health Plan Option.
3. Click the Circle button to select a Health Plan.
4. If you have dependent(s) on your plan or would like to add a dependent, continue and scroll down to the Enroll Your Dependents (Add/Review Dependents). **All dependent names must be capitalized and check the student box**. The Social Security Number (SSN) for all dependents will be required.
5. Click the Store button for the additional options. *The store button will hold your choices until you are ready to submit your final enrollment.* Click the OK button after you have reviewed the confirmation display page and to store the elections. *Do not click the submit button until you have completed all of your options, for example any changes to the dental insurance or flexible choices program.*
6. If there are no additional changes, then click the **SUBMIT** button.
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

Dental Insurance

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the Dental Plan Option.
3. Click the Circle button to select a Dental Plan.
4. If you have dependent(s) on your plan or would like to add a dependent, continue and scroll down to the Enroll Your Dependents (Add/Review Dependents). **All dependent names must be capitalized and check the student box.** The SSN for all dependents will be required.
5. Click the Store button for the additional options. The store button will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
6. If there are no additional changes, then click the **SUBMIT** button
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

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Flexible Choices Programs

If you wish to participate in any of the three parts of the Flexible Choices Program for 2011, you must enroll each plan year. These plans do not automatically renew.

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select Flexible Choices Medical, Dependent Care or Parking Expenses.
3. Click the Circle button to select a Flexible Choices Option or click No, I do not want to enroll.
4. Submit the annual pledge amount for each of the Flexible Choices option you want to be enrolled in 2011.
5. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
6. If there are no additional changes, then click the **SUBMIT** button.
7. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

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Long Term Disability

If you wish to select a Long Term Disability (LTD) buy down of 60, 90,120 day coverage, or change the current buy down selection.

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the LTD Buy Down.
3. Click the Circle button to select the LTD buy down coverage.
4. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
5. If there are no additional changes, then click the **SUBMIT** button.
6. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

Life Insurance

If you wish to change the Supplemental Life Insurance enrollment.

Path: Home/Self Service/Benefits/Benefits Enrollment

1. Click the Select button.
2. Click the Edit button to select the Supplemental Life Insurance option.
3. Click the Circle button to select the Supplemental Life Insurance Plan. If required, you must enter a coverage amount or click the percentage option.
4. Click the Store button, which will hold your choices until you are ready to submit your final enrollment. Click the OK button after you have reviewed the confirmation display page and to store the elections. Do not click the submit button until you have completed all of your options.
5. If there are no additional changes, then click the **SUBMIT** button
6. Please be sure to review and print your confirmation statement when you have completed your benefit enrollment.

For COBRA Enrollees
If you are making a Health/Dental Plan Change for the Year 2011

1 . Write in the **JOB TITLE** box of all enrollment forms.
2 . A COBRA enrollee will write "COBRA" in the JOB TITLE box.
3 . DO NOT write anything in the CITY START DATE and RETURN TO WORK DATE boxes

TELEPHONE NUMBERS & WEBSITES

Employee Benefits Division	**414-286-3184**	**www.Milwaukee.gov/der**

Health Plans

Basic Plan (Anthem Blue Cross Blue Shield)	**1-866-926-7789**	**www.Anthem.com**
United Healthcare Choice Plan (UHC)	**1-866-873-3903**	**www.myuhc.com**
United Healthcare Choice (Vision)	**1-877-426-9300**	**www.mUHCvision.com**
Navitus Health Solutions (Pharmacy)	**1-866-333-2757**	**www.Navitus.com**
Prescription Solutions (Mail Order)	**1-800-908-9097**	**www.PrescriptionSolutions.com**

Dental Plans

WPS/Delta Dental	**1-800-275-6230**	**www.deltadentalwi.com**
Care Plus Dental	**414-771-1711**	**www.careplusdentals.com**
DentalBlue	**1-866-589-0582**	**www.Anthem.com**

If you have any questions regarding your benefits, or regarding unpaid bills, or problems with service, please call your health or dental plan. **DO NOT** call Employee Benefits until you have contacted your health or dental plan and are unable to arrive at a resolution. Employee Benefits will attempt to assist you to resolve your problem, but in no case will Employee Benefits attempt to change, question or provide a medical opinion. Remember to document all your conversations with dates, times and names. We will ask you for this information when you call our office.

Notes